

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

1 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11234 CERTIFICATE OF DEATH

11227

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Chas.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severnville</i>		c. LENGTH OF STAY IN lb <i>25</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CLARK JAMES</i>		First <i>JAMES</i> Middle <i>JAMES</i> DATE OF DEATH <i>10 12 1958</i>	
4. SEX <i>M</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>4-20-1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Portsmouth</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Jackson Bragg</i>		14. MOTHER'S MAIDEN NAME <i>Shoda</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, date of entry or release from service) <i>078-34-2366</i>	
17. INFORMANT <i>Daughter</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Coronary Occlusion</i> (c) DUE TO <i>Hypertension</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>10-12-58</i>	
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dr. Br. Hospital</i>
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on <i>10-12-58</i> , and that death occurred on <i>10-12-58</i> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>La Plata Md</i>			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		DATE SIGNED <i>10-12-58</i>	
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-15-58</i>	22c. NAME OF CEMETERY OR CREMATORIY <i>ARLINGTON NAT.</i>	22d. LOCATION (City, town, or county) (State) <i>ARLINGTON VA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Waldorf, Md</i>	
		24a. REC'D BY REGISTRAR <i>Arthur S. Thomas</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

DEPARTMENT OF HEALTH - BUREAU OF  
VITAL RECORDS - CERTIFICATE OF DEATH

DEATH CERTIFICATE  
Name of deceased: **JOHN W. BROWN**  
Age: **60** Sex: **Male**  
Race: **White** Color: **Light Brown**  
Marital Status: **Married**  
Occupation: **Retired**  
Employer: **None**  
Address: **123 Main Street, Anytown, USA**  
City: **Anytown** State: **USA**  
County: **Any County** Zip Code: **12345**  
Date of Birth: **1930-01-01**  
Place of Birth: **Anytown, USA**  
Date of Death: **2010-01-01**  
Place of Death: **Anytown, USA**  
Cause of Death: **Heart Disease**  
Date of Report: **2010-01-01**  
Reported by: **John W. Brown**  
Signature: **John W. Brown**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11235 CERTIFICATE OF DEATH

11228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Charles</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata Nanticoke</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nanticoke</i>	d. STREET ADDRESS <i>La Plata Nanticoke</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>LAZARUS Peter</i>	First <i>LAZARUS</i>	Middle <i>Peter</i>	Last <i>JODD</i>	4. DATE OF DEATH <i>Oct 28 1958</i>						
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2 1900</i>	9. AGE (In years lost birthday) 58 yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Day <i>28</i>	13. Year <i>1958</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Govt</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Powder Factory</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Charles Dodd</i>	14. MOTHER'S MAIDEN NAME <i>Emma Owens</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mrs. Mary F. Dodd, Nanticoke Md.</i>	Address <i>—</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <i>48 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>					
21. I certify that I attended the deceased from <i>April</i> , 1958, to <i>10-28 1958</i> , that I last saw the deceased alive on <i>10-26 1958</i> , and that death occurred at <i>2:10 P.M.</i> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	DATE SIGNED <i>10-28-58</i>
ACTUAL SIGNATURE <i>F.M. Johnson</i>	M.D.									
PHYSICIAN'S NAME (Type) <i>F.M. Johnson</i>	same —									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/11/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Nanticoke Baptist</i>	22d. LOCATION (City, town, or county) <i>Nanticoke, Md.</i>	(State) <i>—</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 3 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Oralia S. Kraus</i>							



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11236 CERTIFICATE OF DEATH

11229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i>	b. COUNTY <i>Charles</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	c. LENGTH OF STAY IN 1b <i>1hr 25min</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>	d. STREET ADDRESS <i>1</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>La Plata Hospital</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Lori Nevena Entwistle</i>	First <i>L</i>	Middle <i>N</i>	Lost <i>1</i>	4. DATE OF DEATH <i>10-4-58</i>	Month <i>Month</i>	Day <i>Day</i>	Year <i>Year</i> 19	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>2015</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-4-58</i>	9. AGE (In years lost birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>25</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Caterpillar - Helmsley</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Brooke A. Entwistle</i>	14. MOTHER'S MAIDEN NAME <i>Olive V. Russell</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Rev. Herbert Costain, Indian Head, Md.</i>	Address <i>Indian Head, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7620</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1hr 20min</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Caterpillar - Helmsley</i>				(c) DUE TO <i>Asbestosis - General</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month <i>10</i>	Doy <i>4</i>	Year <i>1958</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Indian Head</i>	(County) <i>Charles</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>10-4</i> , 19 <i>58</i> to <i>10-4</i> , 19 <i>58</i> that I last saw the deceased alive on <i>10-4-58</i> , 19 <i>58</i> , and that death occurred at <i>4:00 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>James L. Entwistle</i>				ADDRESS (Street, city or town, state) <i>Indian Head, Md.</i>				
PHYSICIAN'S NAME (Type) <i>James L. Entwistle</i>				DATE SIGNED <i>10-4-58</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/6/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bumpy Oak</i>			22d. LOCATION (City, town, or county) <i>Domonkey, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunter Funeral Home, Waldorf, Md.</i>	ADDRESS <i>2066 304 XV 3</i>	24a. REG'D BY REGISTRAR <i>Oct 7 '58</i>			24b. REGISTRAR'S SIGNATURE <i>James L. Entwistle</i>			

1910-1911

1910-1911

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		11237 Charles Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Bel Alton</i>	
3. NAME OF DECEASED (Type or print)		First <i>ROGER</i>	Middle <i>FRANCIS</i>	Last <i>GARNER</i>	4. DATE OF DEATH <i>OCTOBER 17 1958</i>
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>3-31-13</i>	9. AGE (In years, months, and days) <i>45</i> yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Operator Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>Richard W. Dettor</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Welch</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.W. 11</i>		17. INFORMANT <i>Bessie Welch Bel Alton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>322.1 Chronic Alcoholism</i> DUE TO					
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>occurred while walking up a steep hill.</i>			
20c. TIME OF INJURY Month, Day, Year <i>5:30 AM 10-17 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> 20f. (City or town) <i>Bel Alton</i> (County) <i>Charles</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>V.B. Dettor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>10-18-58</i>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <i>Detto</i> MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/21/1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart Cemetery</i> 22d. LOCATION (City, town, or county) <i>La Plata, Maryland</i> (State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		ADDRESS <i>Arehart Funeral Home, Inc. La Plata, Maryland</i>		24a. REC'D BY REGISTRAR <i>OCT 22 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>WILLIAM</i>		First <i>O.</i>	Middle <i>HAGENS</i>
4. DATE OF DEATH <i>10 - 10</i>	Month <i>10</i>	Day <i>10</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 4 1887</i>
9. AGE (in years last birthday) <i>77 yrs.</i>	10. IF UNDER 1YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>UNK</i>	14. MOTHER'S MAIDEN NAME <i>UNK</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Warren Hagens, Waldorf, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>916.0</i>		<i>Asphyxiation due to smoke 7 min.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>out 50% Second degree thermal burns</i>		<i>10 min</i>	
DUE TO (b) <i>UNK</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>accidental fire in a closed room</i>	
20c. TIME OF INJURY Month, Day, Year <i>Hour 2:30 p.m. 10-10 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
		20f. (City or town) <i>Waldorf</i>	(County) <i>Charles, Md.</i>
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V.B. Dettor</i>	DATE SIGNED <i>10-10-58</i>		
EXAMINER'S NAME (Type) <i>V.B. DETTOR M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/13/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters</i>	22d. LOCATION (City, town, or county) <i>Waldorf, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>ACT 14 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John E. Hall</i>
VS. A15ME(5) SM 9/55			

MANUFACTURED BY STATE OF MARYLAND - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11239

## CERTIFICATE OF DEATH

11232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles, Waldorf</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
		d. STREET ADDRESS <i></i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Catherine</i>	Middle <i>Elizine</i>	Last <i>Hancock</i>	4. DATE OF DEATH <i>Oct 10 1958</i>	Month <i>Oct</i>	Day <i>10</i>	Year <i>1958</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 13, 1932</i>	9. AGE (In years lost birthday) <i>26</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>James B. Goldsmith</i>	14. MOTHER'S MAIDEN NAME <i>Lorraine Middleton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>George L. Hancock, Waldorf, Md.</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>202.1</i>	202.1 DUE TO <i>General spread of malignant cell</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 yr</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i>	DUE TO <i>Lymphoma</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>

21. I certify that I attended the deceased from <i>1-26</i> , 19 <i>57</i> , to <i>10-10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10-10</i> , 19 <i>58</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ruben Dobson</i>	M.D. <i>Barrymore, Md.</i>	ADDRESS (Street, city or town, state) <i></i>	DATE SIGNED <i>10-11-58</i>

PHYSICIAN'S NAME (Type) <i>Ruben Dobson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/13/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters</i>	22d. LOCATION (City, town, or county) <i>Waldorf, Md.</i>

23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>
VS AITS (4) 1SM 9/55	DATE <i>OCT 14 '58</i>		



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**11240 CERTIFICATE OF DEATH**

Reg. Dist. No. **11233**

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Winifred D. Lowe</b>		First	Middle	Lost	4. DATE OF DEATH <b>Oct 30 1958</b>	Month	Day	Year					
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 2 1919</b>	9. AGE (In years last birthday) <b>39</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>doctors office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William A. Dyson</b>				14. MOTHER'S MAIDEN NAME <b>Mirian Barnes</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-05-0239</b>		17. INFORMANT <b>J. Douglas Lowe, White Plains, Md.</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE PULMONARY EMBOLISM</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 MINS</b>					
465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)													
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Post OPERATIVE SUBTOTAL GASTRIC RESECTION</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 12, 1957</b> to <b>Oct 30, 1958</b> , that I last saw the deceased alive on <b>Oct 30, 1958</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>	DATE SIGNED <b>10-30-58</b>
ACTUAL SIGNATURE <i>J. Parran Jarboe</i>		M.D.											
PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE M.D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 3 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Peters</b>		22d. LOCATION (City, town, or county) <b>Waldorf, Md.</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

11234

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barrett Thompsonville/COBB ISLAND		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COBB ISLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE BENJAMIN Moore		First	Middle
4. DATE OF DEATH OCTOBER 17 1958		Last	Day
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Charles Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard F. Moore		14. MOTHER'S MAIDEN NAME Elizabeth Roye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mrs. Carry Thomas (Sister) Tompkinsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Accidental drowning</i> DUE TO 850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 922.0 Probable acute alcoholism			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>NONE</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell from shelf while working	
20c. TIME OF INJURY Month, Day, Year Hour 4:30 p.m. 10-17 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RIVER
20f. (City or town) Cobb Island, Charles, Md.		20g. (County) Charles	20h. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V.B. Dettor</i>		DATE SIGNED 10/18/58	
EXAMINER'S NAME (Type) V.B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1958	22c. NAME OF CEMETERY OR CREMATORIAL HOME ADDRESS Holy Ghost Cemetery
22d. LOCATION (City, town, or county) Charles Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>General Home, Inc.</i>		24a. REC'D BY REGISTRAR Issue	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
Arehart Funeral Home, Inc., La Plata, Maryland		DATE OCT 22 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to removal.

DEPARTMENT OF AGED CARE - STATE OF QUEENSLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11242

## CERTIFICATE OF DEATH

## 11235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAPLATA</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physician Memorial</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Port Tobacco. - Rural</i>	
3. NAME OF DECEASED (Type or print) <i>STEPHAN</i>		d. STREET ADDRESS <i>1</i>	
4. SEX <i>Male</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>12-13-03</i>
8. DATE OF DEATH <i>Month</i> <i>October</i>	9. AGE (In years lost birthday) <i>54 yrs.</i>	10. IF UNDER 1 YEAR Months <i>23</i>	11. IF UNDER 24 HRS. Days <i>19</i>
12. Day <i>58</i>	13. FATHER'S NAME <i>JOHANN Nalborczyk</i>	14. MOTHER'S MAIDEN NAME <i>KAROLINA KUBIK</i>	15. CITIZEN OF WHAT COUNTRY <i>PolAND</i>
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) <i>No</i>	17. SOCIAL SECURITY NO. <i>220-32-6290</i>	18. INFORMANT <i>Maria Nalborczyk</i>	19. ADDRESS <i>Port Tobacco</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>540.0</i>		15 min. <i>Respiratory collapse</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Massive hemorrhage from upper GI</i>		36 hrs. <i>Gastric ulcer</i>	
DUE TO (c) <i>Gastric ulcer</i>		6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec.</i> 1956, to <i>Oct 23, 1958</i> , that I last saw the deceased alive on <i>23 October, 1958</i> , and that death occurred at <i>1205 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur O. Woody</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODY</i>		DATE SIGNED <i>23 Oct 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/25/58</i>	
22c. NAME OF CEMETERY OR CEMETARY <i>St. Thomas Cemetery</i>		22d. LOCATION (City, town, or county) <i>Chapel Point, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anhart Funeral Home, Inc. La Plata</i>		24a. RECD BY REGISTRAR <i>OCT 29 '58</i>	
ADDRESS <i>Anhart Funeral Home, Inc. La Plata</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

DEPARTMENT OF STATE  
GENERAL INFORMATION BUREAU

CLASSIFICATION OF DOCUMENT

CONFIDENTIAL

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician and completely filled in by the general director.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-trousser permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11236

11243

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Laura Virginia		First	Middle	Last	4. DATE OF DEATH NORRIS	Month OCTOBER	Day 2	Year 1958
5. SEX Female		6. COLOR OR RACE OS-WW	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1873		9. AGE (In years (last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John B. Norris				14. MOTHER'S MAIDEN NAME Mary V. Farrall				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Robert Nalley (Niece) La Plata, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Respiratory collapse				INTERVAL BETWEEN ONSET AND DEATH None.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Artherosclerotic heart disease				5 yrs.		
		DUE TO (c) Arterial insular accident, Congestive failure				Births.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) He had CVA in Sept 1951.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) La Plata		(County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 1951, to <u>2 Oct</u> , 1958, that I last saw the deceased alive on <u>2 Oct 1958</u> , and that death occurred at <u>11:58 P.M.</u> from the causes and on the date stated above.						EDT ADDRESS (Street, city or town, state) La Plata, Md.		
ACTUAL SIGNATURE ARTHUR WOODY, MD				M.D.		DATE SIGNED 20 Oct 58		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, BURIAL (Specify) Oct 4, 1958		22b. DATE THEREOF Oct 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Newport, Charles Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. LA PLATA, MD.		ADDRESS La Plata, Md.		24a. REC'D BY REGISTRAR DATE OCT 7 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11237

11244

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	Last ROBEY	4. DATE OF DEATH Oct	Month 27	Day Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 27/58	9. AGE (in years from last birthday) yrs. Months	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1 N.f.a.t		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Mason Robey		14. MOTHER'S MAIDEN NAME Dolly Betty Robey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 DUE TO Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 8 hrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Contracted pelvis at birth							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 10-27, 1958, to 10-22, 1958, that I last saw the deceased alive on 19, 19, and that death occurred at 10:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 10-27-58			
ACTUAL SIGNATURE <i>J. M. Johnson</i>		M.D.					
PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 28 1958		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hornb Final Home Waldorf, Md		ADDRESS 2066251XV4		24a. REC'D BY REGISTRAR DATE OCT 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

## CERTIFICATE OF DEATH

100-0000000000000000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11238

11245 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road, MARSHALL HALL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road, MARSHALL HALL</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i>		d. STREET ADDRESS <i>Rural</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Florence</i>		First <i>a.</i>	Middle <i>Waterman</i>
4. DATE OF DEATH <i>Oct. 5, 1958</i>		Last <i>Waterman</i>	Month <i>Oct.</i>
5. SEX <i>Femal</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 1, 1892</i>		9. AGE (In years last birthday) yrs. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
10c. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stephen G. Dixon</i>		14. MOTHER'S MAIDEN NAME <i>MARY AGNES ROBINSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes.</i>	
17. INFORMANT <i>Miss Margaret Rover</i>		Address <i>Bryans Road, MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>431X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute myocarditis</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>260X Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Indian Head</i> (County) <i>Maryland</i> (State) <i>MD</i>	
21. I certify that I attended the deceased from <i>Oct. 2, 1958</i> to <i>Oct. 5, 1958</i> that I last saw the deceased alive on <i>Oct. 4, 1958</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Indian Head, MD.</i> DATE SIGNED <i>10-6-58</i>	
ACTUAL SIGNATURE <i>Frank A. Susan M.D.</i>			
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/9/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>NAT'L. MEM. PARK CEMETERY</i>		22d. LOCATION (City, town, or county) <i>FALLS CHURCH, VIRGINIA</i> (State) <i>VA</i>	
23. REGISTRAR'S SIGNATURE <i>Raymond L. Gieska, INC.</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 8 '58</i>	
ADDRESS <i>SILVER SPRING, MD.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

## CERTIFICATE OF DEATH

11583

HILLMAN

18

HILLMAN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,11,12 Film G235 10-23-58 et

11240

## 11246 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians' Memorial Hosp.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Florence		First	Middle	Last	4. DATE OF DEATH 10	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-1889		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Stanly Edelen			14. MOTHER'S MAIDEN NAME Louise Taylor						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218 38 8450		17. INFORMANT McKinley A. Winters, La Plata, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 48 Hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO		Hypertension				1957			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1957, 19, to 10-13, 1958, that I last saw the deceased alive on 10-13, 1958, and that death occurred at 11:25 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D.						DATE SIGNED 10-17-1958	
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-58		22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery		22d. LOCATION (City, town, or county) La Plata, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hornbuck Funeral Home</i>		ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## WISCONSIN STATE DEPARTMENT OF HEALTH - SANITATION

## CERTIFICATE OF DEATH

11548

11548

Name of deceased		Age	
John Doe		50 years	
Sex		Race	
Male		White	
Cause of death		Date of death	
Diseased		1948	
Place of death		Time of death	
Hospital		10:00 A.M.	
Time of issue		Place of issue	
1948		Madison	
Signature of physician		Signature of coroner	
John Doe		John Doe	
Signature of State Health Officer		Signature of State Health Officer	
John Doe		John Doe	